

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

8517

Do not use this space.

1. PLACE OF DEATH 12 1840  
 (a) County St. Louis Registration District No. 968  
 (b) Township St. Louis Primary Registration District No. 6184  
 (c) City St. Louis (d) Street No. 11 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Arthur W. Dotson (DOTSON)  
 (a) Residence, No. same St. MO (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>mn</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>			21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Feb 10 1940</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					22. I HEREBY CERTIFY, That I attended deceased from <u>2/9/40</u> , 19 <u>40</u> , to <u>2/10/40</u> , 19 <u>40</u> I last saw him alive on <u>2/10/40</u> , 19 <u>40</u> . Death is said to have occurred on the date stated above, at <u>7 a.m.</u> The principal cause of death and related causes of importance were as follows: <u>causing Spinal Meningitis</u> <u>primary Otitis Media</u> <u>Other Pneumonia</u> Date of onset <u>2/9/40</u> <u>2/9/40</u>	
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 20 1934</u>						
7. AGE	YEARS <u>5</u>	MONTHS <u>5</u>	DAYS <u>20</u>	If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>child</u>					
	9. Industry or business in which work was done, as saw mill, bank, etc.					
	10. Date deceased last worked at this occupation (month and year)				11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) <u>St. Louis</u> (STATE OR COUNTRY) <u>MO</u>					Other contributory causes of importance: <u>100</u>	
FATHER	13. NAME <u>Harry Dotson (DOTSON)</u>				Name of operation..... Date of.....	
	14. BIRTHPLACE (CITY OR TOWN) <u>Grandford, Ct</u> (STATE OR COUNTRY) <u>MO</u>				What test confirmed diagnosis?..... Was there an autopsy?.....	
MOTHER	15. MAIDEN NAME <u>Glydus Phares</u>				23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19..... Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.	
	16. BIRTHPLACE (CITY OR TOWN) <u>Peters</u> (STATE OR COUNTRY) <u>MO</u>				Manner of injury..... Nature of injury.....	
17. INFORMANT (ADDRESS) <u>Glydus Dodson</u> <u>Calderonia MO</u>					24. Was disease or injury in any way related to occupation of deceased? <u>No</u> If so, specify <u>D. M. Davidson, D. O. P.</u> (Signed) <u>Calderonia MO</u> (Address) <u>Calderonia MO</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Shirley</u> DATE <u>Feb 11 1940</u>						
19. FUNERAL DIRECTOR (NAME) <u>Stark</u> (ADDRESS) <u>Peters MO</u>						
20. FILED <u>Mar 2 1940</u> <u>D. M. Davidson</u> Local Registrar						

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

B  
40  
659

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 80-17

Registration District No. 468

Primary Registration District No. 6184

Registrar's No.

1. PLACE OF DEATH:

- (a) County Wash  
(b) City or town Harmony, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Arthur W. DOTSON

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, or child

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 5 Months 5 Days 20 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

- (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) DEC-27-40 (b) Dr. H. Houston (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County  
(c) City or town (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 2 day 10 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19 and that death occurred on the date and hour stated above. Immediate cause of death

- Due to

- Due to

- Other conditions (Include pregnancy within 3 months of death)

- Major findings: Of operations

- Of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)

- (b) Date of occurrence

- (c) Where did injury occur? (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? (Specify type of place) (e) Means of injury

23. Signature Dr. M. D. Harrison (M. D. or other)

- Address Belgrade, Mo. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

